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ABSTRACT

The purpose of this survey was to assess public attitudes about drug addiction, addicts, and treatment for this condition. Four reference groups were sampled: (1) law-enforcement representatives; (2) college student non-users; (3) student users of marihuana; and (4) post-withdrawal narcotic addicts. Data was obtained from a questionnaire consisting of 35 bipolar descriptive statements, to which subjects were to assign a rating from one to five, indicating their agreement, neutrality or non-agreement with each of the statements. An additional 11 items assessed the potential helpfulness of different classes of people to the drug addict. Responses to the 35 descriptive items and to the 11 helpfulness ratings were submitted to principal component factor analyses. Four were extracted from the descriptive statements: (1) social rejection; (2) psychological intervention; (3) threatening, harmful; and (4) nonpunitive reaction. Likewise, four were extracted from the helpfulness ratings: (1) semi-professionals; (2) mental health professionals; (3) adjunct professionals; and (4) family and friends. Results are presented. A concluding discussion elaborates the findings and attempts some minimal interpretation of them. (TL)

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A Survey of Attitudes Toward Drug Addiction

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The Harrison Act of 1914, passed by Congress to regulate and control the distribution of drugs in the United States, became the cornerstone for subsequent criminal legislation and prohibitive court interpretations regarding drug addiction. Almost overnight victims of drug addiction were transformed into criminals (Nyswander, 1963; Murtaugh, 1962; Lindesmith, 1966) to be scorned and feared by the general public, harassed, exploited, and hunted by law enforcement officials, and totally abandoned by the medical profession. As a consequence of very punitive attitudes about addiction, little headway has been made in development of programs for rehabilitation, behavior modification, and prevention. Only recently, due primarily to the obvious inadequacy of a strictly law enforcement approach (Schur, 1964), have adverse public attitudes become more moderate (Pattison, Bishop, & Linsky, 1968) and new treatment programs, based on medical and social-psychological concepts, begun to emerge.

The purpose of this survey was to assess public attitudes regarding drug addiction, the drug addict, and treatment for this condition. Four reference groups that have had an influence in shaping attitudes about addiction were sampled. These included samples of law enforcement representatives, college student nonusers, student users of marijuana, and a sample of post-withdrawal narcotic addicts.

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METHOD

The data for this survey was obtained from a questionnaire consisting of 35 bipolar descriptive statements within a 5-point semantic differential format. The descriptive statements were selected from prominent topics in the clinical and research literature relevant to the general area of mental health and dealt with questions concerning etiology (e.g., physical versus psychological causes), treatment (e.g., professional, self-help, punishment, etc.) and a range of personal evaluative attitudes and reactions (e.g., can be trusted, harmful, repulsive, etc.). Ss indicated their views of "People who are drug addicts" by ratings of the 35 bipolar descriptions. For example, one item stated that ("People who are drug addicts) "Are responsible for their condition" on one pole and "Not responsible for their condition" on the opposite pole. Assignment of "3" would indicate a neutral rating or nonagreement with either polar statement. A rating of "1" or "2" would indicate very much or some agreement (respectively) with the statement that drug addicts are responsible for their condition while a rating of "4" or "5" would indicate agreement with the statement that they are not responsible for their condition.

An additional 11 items were included which assessed the potential "helpfulness" of different classes of persons (such as friend, psychiatrist, minister, and so on) to the drug addict. These ratings were made on a 5-point intensity scale ("1" indicating "not very helpful" to "5" or "extremely helpful").

Ss completed the questionnaire in small groups. Anonymity and expression of personal opinions and feelings were emphasized in the instructions. The questionnaire was administered to samples of Ss from four different populations. These included 228 Vanderbilt University undergraduate students who reported never having used marijuana, 65 students from the same population who anonymously admitted to smoking marijuana on at least one occasion (modal useage was more than 10 occasions), 55 Nashville, Tennessee, policemen in the final stages of a four month training program, and 87 narcotic addicts committed to the National Institute of Mental Health Clinical Research Center at Lexington, Kentucky. All members of the addict sample had been morphine or heroin users and had completed withdrawal from these drugs.

RESULTS

In order to facilitate comparisons among the four reference groups, responses to the 35 descriptive items and to the 11 helpfulness ratings were submitted to principal component factor analyses. The four factors extracted from the descriptions accounted for 26 of the 35 descriptive statements (minimum loading .30) and the four factors from the helpfulness ratings accounted for all 11 persons (minimum loading .30). Since the purpose of this survey was to identify overlapping and disparate views among the four reference groups, emphasis will be placed on the relative position of groups on items for each factor. Unless otherwise

stated, group differences were significant at less than .01 as tested by Duncan's Range Test following overall significant one-way analyses of variance.

Factor I (Social Rejection), of the descriptions, was designated by items that seemed to emphasize social rejection and deviance. Within this factor there were two distinct sub-clusters of items. One cluster consisted of items that described the drug addict as socially distant from the respondent and as having negative personal characteristics. Thus, the addict was seen as having problems different from those the respondent might have, as being "repulsive," "not the type of people (one would) choose as close friends," and unpredictable in their behavior. The second cluster consisted of items which indicated that addicts "needed to be cared for" on a "long-term" basis and would best profit from the "direct advice" of others. While these items relate to social deviance, they also imply that resocialization would require a long-term and guided effort.

As seen in Table 1, relative to the other groups, policemen reacted more intensely to <u>all</u> items of this factor; college student nonusers, while directionally similar to responses of policemen, gave somewhat less intense ratings; marijuana users gave generally more moderate ratings than nonusers and tended to support the views of drug addicts; while the drug addict sample fairly consistently responded in an opposite pole to policemen and nonusers.

For the most part, policemen and nonusers saw the addict as having problems that were dissimilar to their own, that the addict was repulsive and behaviorally unpredictable, and required long-term assistance. Policemen felt significantly more strongly than the other reference groups that addicts "needed to be cared for," required "direct advice" and were not the type of people (they) would choose as close friends. Marijuana users were generally less socially rejecting of the addict than policemen and nonusers. They indicated that the addict's problem was somewhat similar to their own, that they did not view addicts as repulsive, and would be more inclined to choose them as close friends. Marijuana users did agree with policemen and nonusers that addicts require long-term assistance although they tended to disagree that direct advice was required. Addicts, themselves, expressed opposite views to those of policemen and nonusers, particularly on items that related to the type of assistance needed (the second subcluster of items). On these items addicts indicated that they needed to care for <u>themselves</u>, to find their <u>own</u> answers to their problems as opposed to gaining direct advice from others, and that <u>short-term</u> rather than long-term assistance was required. Addicts did agree with nonusers that they would not choose other addicts as close friends, and that the addict behaves "unpredictably."

In general, responses to items on Factor I followed the pattern that policemen and addicts held opposite opinions on interpersonal reaction and need for intervention. College student nonusers tended to side with policemen in terms of the direction

of their ratings but held more moderate views. Marijuana users sided with addicts in terms of having more positive interpersonal reactions to addicts but tended to disagree with addicts on the need for long-term guided assistance with their problem.

Factor II (Psychological Intervention) was defined by a more consistent set of items than Factor I. Items which loaded on Factor II had the common theme that the addict's problem was essentially psychological (rather than physical or medical) in nature and that long-term psychiatric intervention aimed at emotional release was called for. The four reference groups agreed that addicts had mostly a psychological problem and users, nonusers, and policemen agreed that long-term psychiatric assistance was needed. Addicts themselves indicated that assistance should be short-term (rather than long-term) and they were less inclined to ascribe learning experience as a determinant of their addiction.

Factor III (Threatening, Harmful) described a variety of negative interpersonal reactions to addicts. In particular, that addicts "could be harmful to others," that they have a tendency to frighten people and to make them angry and that the addict cannot be trusted. Interestingly, all four reference groups agreed that addicts are somewhat embarrassed about themselves and that they "definitely can improve," suggesting perhaps that the negative traits described in this factor are potentially modifiable. The four reference groups generally agreed that the addict is

frightening to others and makes others angry although policemen made nonsignificantly more intense ratings on these items than the other groups. Marijuana users, on the other hand, expressed more lenient attitudes than the other groups on whether addicts could be harmful, make others angry, are embarrassed about themselves and can be trusted. On five of the six items which loaded on this factor, the mean ratings of policemen and marijuana users were disparate in opposite directions (but were still on the same item pole).

Factor IV (Nonpunitive Reaction) suggested that the drug addict is somewhat sensitive to reactions of others, requires understanding of his feelings rather than his action, and that while he is responsible for his condition, he should be protected rather than punished for his mistakes. Policemen took a more punitive position than the other groups in assigning responsibility to the addict for his condition and in requiring punitive payment for his mistakes. Nonusers and addicts responded in an identical manner in the nonpunitive direction but were significantly more moderate in their views than marijuana users who ascribed to a very lenient, nonpunitive position. Policemen, nonusers and addicts agreed that the addict was responsible for his condition while on the average marijuana users were neutral on this question. All groups did agree that the addict required understanding of feelings more so than actions.

There were several items that did not load on any of the four factors but present further information. For example, all four reference groups agreed that little is known about drug addiction, that drug addicts do not look different from other people, that addicts themselves generally recognize they have a problem, that their problem is not religious, but the addict will "eventually be helped by changing his environment." Policemen, however, felt that the addict would be "harmed by sympathy" while the other groups took the position that, to some degree, the addict might "benefit from sympathy." It is interesting to note that both addicts and policemen samples felt that addiction could be prevented with present knowledge. Student nonusers were neutral on this question but marijuana users felt that addiction could not be prevented with present knowledge. It is also interesting to note the relative alignment of the four groups over all the items in the questionnaire. On 29 of 35 items, the mean for the police sample was the most intense in one response direction. In 16 of these 29 instances, the marijuana user sample held the relative opposite position (and 6 of these 16 times responded in the opposite polar direction), ten times the drug addict sample held the more deviant position from policemen, and, on only three occassions, the nonuser sample expressed a relatively opposite view from policemen. In general, responses of addicts paralleled those of the nonuser sample while police and marijuana users occupied positions on either side of these groups.

Referring to Table 2, Factor I (Semi-Professional), of the helpfulness ratings, found counselors, social workers and volunteer workers together. All these types were viewed as moderately helpful by the four reference groups. Factor II (Mental Health Professional) produced a pairing of mental health professionals - psychiatrists and psychologists - and physicians, all of whom were perceived as very helpful by policemen, nonusers and marijuana users and as moderately helpful by addicts. Factor III (Adjunct Professionals) included law enforcement officers, politicians and ministers. Politicians were uniformly rated as not very helpful as were policemen (except by the police sample who rated them as moderately helpful). Ministers were seen as somewhat helpful by addicts and marijuana users but as significantly more helpful by policemen and nonusers. Factor IV (Family and Friends) identified family members and friends as moderately helpful by respondents with the exception of marijuana users and nonusers who rated friends as very helpful.

Overall, policemen felt that psychiatrists and psychologists (followed by ministers) would be the most helpful persons for drug addicts, nonusers ranked psychiatrists, family members, physicians and psychologists (in that order), marijuana users identified friends and physicians highest followed by psychiatrists and psychologists, and addicts, although they did not rate any person as more than moderately helpful, ranked friends, psychiatrists and physicians as equally helpful, followed by psychologists and family members.

DISCUSSION

It is important to emphasize the need for caution in generalizing from the rather select and homogeneous samples in this survey to their respective populations and in trying to establish conclusions regarding the effect of these attitudes on treatment of drug addicts. Nevertheless, in view of the relative paucity of information about attitudes on addiction, tentative conclusions - hopefully to be validated by further research - will be offered.

In general, Ss tended to view the drug addict as socially distant and interpersonally aversive. The addict was characterized by respondents as responsible for his condition, potentially harmful and frightening, provoking, somewhat repulsive, untrustworthy, and unpredictable. This combination of attributes would seem to match stereotypes of the antisocial or criminal individual (Sieveking & Doctor, 1969). In part, these reactions probably reflect a publically held stereotype of addicts that is reinforced by criminal role expectancy and hostile police attitudes (Schur, 1964, Grennan, 1962) rather than representing impressions gained from direct personal contact with addicted individuals. For example, it is well documented that addicts, if forced to resort to criminal activities, are typically nonviolent and nonassualtive (Task Force Report, 1967) and that interpersonnally they appear quite nonaggressive, passive, dependent, conservative,

inhibited, fearful and tend to rely on fantasy as an adjustive technique (Campbell, 1962; Ausabel, 1958). Furthermore, field studies find the social and physical communities of addicts are not transient and ill-formed, as might be expected with strictly criminal individuals, but have a high degree of structure, interdependence, and residential stability (Schumann, Caffrey, & Hughes, 1970).

While respondents tended to identify and react to addicts as criminals, they also expressed the view that the crucial determinants of addiction were socio-psychological (rather than medical, physical or hereditary) and that through long-term direction by a mental health professional, the addict had potential for improvement. This emphasis on "psychological" determinants and the clearly non-punitive view of appropriate treatment is congruent with current campaigns to educate professionals and to temper public opinion (Schur, 1964, Pattison, Bishop and Linsky, 1968). While the necessity for a lengthy and intensive program of reshaping behavior has been recognized by self-help lay groups such as Synanon (see Yablonsky, 1965) and Addicts Anonymous, most state and federal programs still adhere to essentially a detention model. In this regard, it is interesting to note that addicts themselves tended to minimize the seriousness of their problem in terms of duration and extent of treatment required. This

tendency to deny illness and to adopt unrealistic and unwarranted optimism has also been noted by Blachly, et al. (1961), in their survey of addict attitudes after three months of hospitalization. Undoubtedly, the conflict of addict and professional views hampers if not undermines treatment efforts.

One of the most prominent patterns of response among the four reference groups was the tendency for police and marijuana users to hold relatively opposing points of view while nonusers and addicts tended to take similar and more intermediate positions. The antiauthoritarian, nonrestrictive, nonpunitive and socially tolerant views expressed by marijuana users as compared with the more punitive and rejecting opinion of policemen cannot be attributed solely to differences in socio-economic background since nonusers, who held more moderate beliefs, came from a similar social class as marijuana users. It is possible that the nonpunitive and tolerant attitudes expressed by student users were the result of greater direct contact with addicted individuals and that such contact had a liberalizing effect on their attitudes. Some evidence for this contention has been reported by Levitt, Baganz, and Blachly (1963) who noted that direct contact with addicts resulted in a greater lessening of cynical, rejecting, and punitive views than indirect contact. If this is the case, programs of rehabilitation might profitably rely on community contact and resources as a means of integrating the addict and achieving more positive public attitudes.

Addicts themselves agreed with the negative reactions expressed by members of other groups and also indicated no desire to have fellow addicts as close friends. This apparent dislike and distrust of members of the same subculture would seem to raise some interesting questions. For example, is the perceived aversiveness and rejection of other addicts an indirect result of the addict's plight, i.e., being hunted and exploited, thus serving as a protective reaction against associating with individuals who might be arrested or turn them in? Or are these reactions expressions of socially immature individuals who are intolerant of others? In any event, the addict's reactions to other addicts have important implications for identifying behavioral targets for treatment and for developing effective treatment programs.

Psychologists, psychiatrists and physicians were rated as most helpful to the addict followed by friends, family members, and ministers. Policemen and politicians were uniformly seen as not very helpful in spite of the fact that these two organizations have had the greatest effect on public and professional attitudes about addicts and treatment for addiction. While American medical opinion has come to view the physician in an ancilary treatment role (Chapman, 1962), medical personnel have been very successful as prime treatment agents in Britain (Schur, 1964) and most informed professionals agree that physicians and mental health

workers should have prime responsibility and complete freedom in treating problems of addiction. Likewise, while there is recognition of the potential helpfulness of ministers, family members, and friends, public support has favored medical and psychiatric intervention rather than more socially broad-based programs. If the history of treatment models for alcoholism and mental illness is indicative of where public policy and support will be directed and strengthened (Pattison, Bishop and Linsky, 1968), the role of the nonprofessional in the treatment of drug addiction should become more prominent.

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TABLE I

Factor items for 35 Descriptive Statements, Group Means, and Fs

Factor I (Social Rejection)

item[a]	mean item score: users	addicts	nonusers	police	F[b]
Have problem similar to my own.....	3.48	1.95	4.18	4.58	90.9***
Have same problem as person I know.....	2.51	2.09	3.68	4.04	36.9***
Are not repulsive.....	2.23	2.72	3.29	3.51	16.5***
Can care for themselves.....	3.43	2.75	3.55	4.31	17.7***
Not type of people would choose as close friends.....	2.69	2.30	2.16	1.64	8.2***
Require short-term assistance.....	3.79	2.95	4.11	4.29	20.3***
Need the direct advice of others.....	2.89	3.32	2.42	1.82	16.6***
Are above average intelligence.....	2.82	2.50	2.95	2.98	4.7**
Behave predictably.....	3.72	3.47	3.86	4.33	5.9***

Factor II (Psychological Intervention)

item	mean item score: users	addicts	nonusers	police	F
Ought to hold in their emotions.....	3.92	3.76	3.68	3.89	1.0
Need psychiatric help.....	2.05	2.06	1.75	1.35	4.9**
Have mostly a psychological problem.....	2.19	1.84	2.08	1.69	2.9*
Acquired their condition after birth.....	1.60	2.33	1.58	1.40	12.2***
Require short-term assistance.....	3.79	2.95	4.11	4.29	20.3***
Have physical disease as cause.....	3.89	3.64	3.73	3.44	1.5

TABLE I (cont.)

Factor III (Threatening, Harmful)

item	mean item score users	addicts	nonusers	police	F
Could be harmful to others	2.59	1.95	1.65	1.46	17.0***
Often make others angry	2.52	2.14	2.28	1.93	3.5*
Frighten others	2.35	2.24	2.45	1.82	4.4**
Are embarrassed about themselves	3.31	2.83	2.91	3.02	1.9
Definitely can improve	1.95	1.71	1.81	1.47	2.8*
Can be trusted	3.23	4.08	3.71	4.16	9.2***

Factor IV (Nonpunitive Reaction)

item	mean item score users	addicts	nonusers	police	F
Are damaged by reactions of others	2.03	2.56	2.28	2.84	6.1***
Should be protected from their mistakes	2.39	2.86	2.82	3.09	3.7*
Should be punished for their mistakes	4.23	3.60	3.45	2.95	10.8***
Are responsible for their condition	2.99	2.43	2.40	2.06	6.5***
Require more understanding of their feelings than actions.	1.91	2.17	2.01	1.86	1.0

a. Low score indicates agreement with item pole stated. High score indicates agreement with opposite item pole (not stated).

b. df 3/434, * = $P < .05$, ** = $P < .01$, *** = $P < .001$

TABLE 2

Factor items for "Helpfulness" Ratings, Group Means, and Fs

Factor I (Semi-Professional)					
item[a]	mean item score users	addicts	nonusers	police	F[b]
Counselors	2.75	2.79	2.79	2.89	.2
Social Worker	2.55	2.84	2.85	2.95	1.4
Volunteer Worker	2.26	2.41	2.39	2.60	.8
Factor II (Mental Health Professional)					
item	mean item score users	addicts	nonusers	police	F
Psychiatrist	4.02	3.62	4.18	4.49	10.6***
Psychologist	3.92	3.43	4.08	4.29	10.5***
Physician	3.75	3.44	4.03	4.33	7.9***
Factor III (Adjunct Professionals)					
item	mean item score users	addicts	nonusers	police	F
Law Enforcement Officer	1.45	1.56	1.80	3.20	38.7***
Politician	1.29	1.59	1.38	1.62	2.3
Minister	2.71	2.60	3.31	3.71	14.4***
Factor IV (Family and Friends)					
item	mean item score users	addicts	nonusers	police	F
Family Member	3.06	3.29	3.29	3.46	1.0
Friend	4.08	3.51	4.11	3.66	7.9***

a. Low scores indicate "not very helpful" and high scores indicate "extremely helpful."

b. df 3/434, * = $P < .05$, ** = $P < .01$, *** = $P < .001$